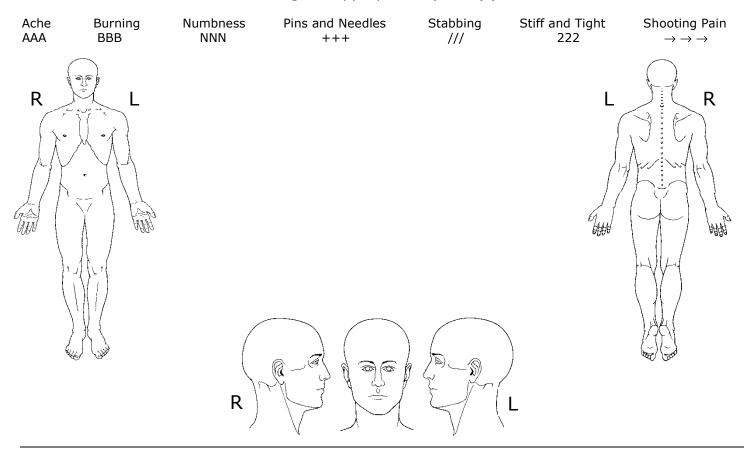
New Patient Questionnaire	Today's Date:
Last Name Initial First Name	Home #
Address	Work #
City / Postal Code	Cell #
Male Female Date of Birth (MM/DD/YY)	Email
Name of spouse or significant other	Employer
Number of children	Occupation
Personal Health Number (Care Card)	Do you have private insurance for chiropractic?
Family Doctor	If so, how much is your annual benefit?
How did you hear about our office?	Do you have BC premium assistance coverage? Y/N
Purpose of this Visit	Height
Why are you here today?	Weight Wt changed 10 lbs or more in the last year? Y / N
Is today's visit the result of: a CAR ACCIDENT? an INJURY AT WORK?	Please list any medications you take
When did today's problem start?	or surgeries you have had
Have you experienced this before?	
Has it gotten BETTER WORSE stayed the SAME	
How long has this been bothering you?	
How often does this bother you?	Please list any dietary supplements you take
What makes it better?	e.g. vitamins and minerals
What makes it worse?	
Please describe any accidents or other injuries you have had	
Please describe your exercise habits	

Please draw the location of any symptoms you may have on the body outline below, using the appropriate symbol(s).



Please CHECK anything that applies to you now, or CIRCLE anything that applied in the past.

GENERAL:

□ Cancer □ Stroke Diabetes □ Unexplained weight change □ High blood pressure □ Osteoporosis **NECK:** □ Neck pain Headaches □ Jaw problems □ Stiff neck and shoulders □ Dizziness or balance problems □ Sinus problems □ Numbness or tingling in: □ Visual problems □ Low energy or fatigue shoulders, arms or hands □ Weakness in grip □ Thyroid problems **MID-BACK:**

□ Rib problems

Heart problems
 Stomach problems
 Indigestion or heartburn
 Asthma, allergies, or wheezing
 LOW-BACK:
 Low-back pain
 Sciatica
 Painful or irregular menstrual

Lung problems

□ Stiff low-back □ Muscle cramps in legs or feet □ Sexual dysfunction □ Constipation or diarrhea □ Frequent or difficult urination

Have any of your BLOOD RELATIVES had any diseases or significant health concerns? If so, please describe below. (M=Mother F=Father B= Brother S=Sister G=Grandparents)